



**American Samoa Medicaid State Agency
Office of the Governor
American Samoa Government**



MEDICAID PROVIDER ENROLLMENT APPLICATION

I/We, hereby apply to participate as a Provider and request for assignment of a Vendor and Provider Number under the American Samoa Medicaid Program.

Please Type or Print in Ink

Legal Business Name: _____

Doing Business As (D.B.A): _____

Type of Applicant (*check one*): Hospital FQHC/CHC Supplier Private Provider

Provider Medicare Identification Number: _____

Current Medicare Fiscal Intermediary or Carrier: _____

Tax ID#: _____ NPI#: _____ Business License #: _____

Business Mailing Address: _____

Email: _____ Telephone: _____ Fax: _____

Attach Applicable Addendum:

PLEASE PROVIDE COPY OF CURRENT LICENSE/CERTIFICATE OF THE EIN, TAX ID, NPI, BUSINESS, AND MEDICARE APPROVAL/CERTIFICATE (*Hospitals/Facilities/Suppliers must be Medicare Certified*).

PLEASE ATTACH LIST OF ALL PARTICIPATING PHYSICIANS OR ANY HEALTH PROFESSIONALS AFFILIATED WITHIN GROUP OR FACILITY PRACTICE WHO WILL BE PROVIDING SERVICES AND INDICATE CURRENT PROFESSIONAL LICENSES/CERTIFICATES INFORMATION BELOW, AND ATTACH COPY OF CURRENT LICENSE/CERTIFICATE INCLUDING CURRICULUM VITAE, DIPLOMA, NPI, ETC. (ADD ADDITIONAL SHEETS IF NEEDED).

PROVIDER NAME	SPECIALTY	NPI#	PROFESSIONAL LIC/CERT#	ISSUE DATE	EXPIRATION DATE

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medicaid Program Provider: The EPSDT (age 20 years and below) comprehensive and preventive health care services must be performed by licensed physician and services must be in accordance to the EPSDT program guidelines, policies, procedures and regulation.

American Samoa Medicaid Program Provider Agreement And Conditions Of Participation

The Provider agrees to the following terms and conditions:

1. To abide by the applicable provisions of the American Samoa Medicaid Program. Upon certification by the American Samoa Medicaid Program, I /We agree to abide by the policies and procedures contained in the American Samoa Medicaid State Plan.
2. To comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352), Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), and the Age Discrimination Act of 1975 (P.L. 94-135), and all the requirements issued pursuant to the respective Title, Section and/or Act as promulgated by the regulations of the U.S. Department of Health and Human Services and hereby give assurance that I/We will immediately take any measure necessary to enact this agreement, to the effect that no person shall on the grounds of the applicable categories such as race, color, national origin, sex, age or handicap, be excused from participation in, or be denied the benefits of, or be otherwise subjected to discrimination under any program and/or activity.
3. To keep all records necessary to disclose fully, upon request, the extent of care and/or services provided to eligible American Samoa Medicaid beneficiaries, and to furnish these records to the American Samoa Medicaid State Agency, the Secretary of the U.S. Department of Health and Human Services, and any other regulatory agency as requested.
4. To comply with the provisions of HIPAA. In this Agreement “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, Pub L. No.104-191.
5. That (1) information provided by American Samoa Medicaid State Agency to a provider and by a provider will be treated confidentially and shall not be released to other agencies or persons without the written consent of the recipient. (2) Any information about Medicaid Providers and recipients shall be confidential, and shall not be disclosed. Such confidential information includes, but is not limited to the names and addresses of individuals, social and economic circumstances of an individual, evaluations, and medical, psychological or psychiatric information about the individual.
6. To accept the established American Samoa Medicaid Programs reimbursement and payments as full payment and not to bill, accept or retain payment from patients or relatives for any additional amount other than the required co-payment and co-shares and payments for non-covered services

7. To utilize patient's medical insurance resources, including but not limited to Medicare, private insurance, and insurance provided by employers before submitting claims to the Medicaid office.
8. To submit all charges within one (1) year after service date except for Medicaid with Third Party Liability (TPL) which should be submitted within sixty--(60) additional days from the receipt date of the TPL payments/statements.
9. To submit all claims/bills via the following options listed by preference:
 - a. First option: Email "finance@medicaid.as.gov"
 - b. Second option: Fax "684-699-4780"
 - c. Third option: USPS

American Samoa Medicaid State Agency
Finance Division
P.O. Box 998383
Pago Pago, American Samoa 96799
Telephone Number: (684) 699-4777/4778/4779
Fax Number: (684) 699-4780

10. To assume total responsibility for collecting required patient co-payments, co-insurances and other patient liabilities;
11. The violation of any of the conditions stated above would mean either of the following depending upon the discretion of the Director of the Medicaid State Agency:
 - a. Withholding of claims and payments until a thorough investigation is made, or;
 - b. Denial of payment and /or suspension or termination from participation.
12. That all services for which we make a claim against the Medicaid will personally be rendered by us. Services such as administration of injections, immunization, minimal dressing and drawing of blood samples may be rendered by qualified support staff and billed to Medicaid.
13. To provide the Medicaid State Agency any operation updates as soon as changes are in effect to include the list of physicians or any health professionals affiliated within institutional practice and renewal, termination or suspension of licenses and certificates.
14. That claims reconciliation is limited to three (3) years from the date of service.

15. To have a criminal history record check(s) conducted on all employees consistent with Federal Law.

16. We may be suspended or terminated from participation in the American Samoa Medicaid Program for non-adherence to any of the program requirements contained in the Medicaid State Plan and Medicaid Policies and Procedures, and for violation of any provisions including, and not limited to, the following:
 - a. Full and accurate disclosure of any person or persons convicted of a criminal offense relating to Medicaid or Medicare;
 - b. Fraud against the Medicaid Program, including but not limited to, the claiming and receipt of payment or payment for services not rendered, submission of a duplicate claim to the Medicaid program with intent to defraud and acceptance of payments for services already paid, or deliberate preparation of a claim in a manner which causes higher payments than the amount entitled to.
 - c. Requiring and receiving payment from a beneficiary that is a covered benefit under the American Samoa Medicaid State Plan.

17. That this agreement may be terminated by a 60-day written notification by either the Provider or the Director of the Medicaid State Agency.

We have read all of the Provider Agreement and Condition of Participation in the American Samoa Medicaid Program and fully understand and agree to its terms.

Provider's Authorized Representative Signature

Date

Print Provider's Authorized Representative Name

Provider's Authorized Representative Title

The Medicaid State Agency agrees:

1. To reimburse Provider for covered services in accordance with the American Samoa Medicaid program covered benefits.

2. That the American Samoa Medicaid State Agency will provide the Provider with written notice(s) of changes to the American Samoa Medicaid State Plan policies and procedures within thirty--(30) days of the effective date of said changes.
3. To process all “clean” claims within forty-five (45) days after receipt of invoices from Provider, clean claims are claims that can be processed without obtaining additional information and /or documentation from the Provider for the service.

I have read the agreement/conditions of the American Samoa Medicaid Provider Agreement and fully understand and agree to the terms and conditions provided therein.

Medicaid's Authorized Representative Signature

Date

Print Medicaid's Authorized Representative Name

Medicaid's Authorized Official Title

FOR AMERICAN SAMOA MEDICAID STATE AGENCY USE ONLY

Approved:

Sandra King Young, Medicaid Director

Date

Effective Date of Contract:

Date of Contract Terminated:

ASG Vendor No:
